Identifying Data:
Full Name:AR
Address: Astoria
Date of Birth: December 6, 1957
Date & Time: January 28, 2022 @ 1pm
Location: Astoria Statcare
Religion: Not Identified
Source of Information: Mother and self
Reliability: Reliable
Mode of Transport: Ambulatory walk-in

Chief Complaint: " not feeling good" x 12 hours

6yo 3 months M with no PMH presents to urgent care today with x 12 hours. Pt states he doesn't feel well since yesterday. Parent states that he hasn't been acting like himself, lethargic, lack of appetite and had a fever of 102 orally this morning. She gave him Motrin and it went down but he is still not feeling well so she brought him here. Pt able to answer his name and birthday. Pt denies any pain in his extremities or stomach. Pt denies his throat hurting, congestion, SOB or headache. Pt mother states that his bowl movements have been normal and no nausea, vomiting, diarrhea or constipation. Pt mother states he has never been hospitalized or had any surgeries. Pt denies any sick contacts, food/medication/exposure changes.

Past Medical History
None

Past surgical history
None

Past Hospitalization history
None

Medications
No medication taken

Allergies:
Denies any food/environmental/medication allergies

Social History:
7yoM lives with parents in Astoria, NY.
Diet: American
Travel: no recent travel

Review of System:
General: Fever (orally subjective in past) and loss of appetite present. Denies any, chills, weight loss.

Skin, hair, nails: Denies changes in texture, excessive dryness or sweating, moles/rashes, pruritus or changes in hair distribution.

Head : Denies headache, vertigo, head trauma, unconsciousness, or coma

Eyes: Denies any visual disturbances, lacrimation, photophobia, or pruritis.

Ears: Denies any deafness, pain, discharge, tinnitus or use of hearing aid

Nose/sinuses: Denies any nasal discharge, epistaxis or obstruction

Mouth/Throat: Denies bleeding gums, sore tongue, sore throat, mouth ulcers, voice changes or use dentures.

Neck: Denies any stiffness or decreased range of motion, lymphadenopathy

Breast: Denies lumps, nipple discharge, or pain.

Cardiovascular system: Denies palpations, chest pain, irregular heartbeat, edema/swelling of ankles or feet, syncope, diaphoresis, orthopnea, claudication or known heart murmur.
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Pulmonary system: Denies SOB, cough, wheezing, pleuritic chest pain, hemoptysis, cyanosis, orthopnea, or paroxysmal nocturnal dyspnea (PND).

Gastrointestinal system: Denies current nausea, vomiting, diarrhea, constipation, intolerance to specific foods, dysphagia, pyrosis, unusual flatulence or eructation, jaundice, hemorrhoids, constipation, rectal bleeding, or blood in stool.

Genitourinary system: Denies dysuria, frequency, hematuria, nocturia, oliguria, dysuria, incontinence, awakening at night to urinate or flank pain.

Nervous: Denies seizures, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition / mental status / memory, or weakness.

Musculoskeletal system: Denies muscle/joint pain, deformity or swelling, redness or arthritis.

Peripheral vascular system: Denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema or color changes.

Hematological system:. Denies lymphadenopathy, easy bruising or bleeding, blood transfusions, or history of DVT/PE.

Endocrine system: Denies polyuria, polydipsia, polyphagia, heat or cold intolerance, excessive sweating, hirsutism, or goiter

Psychiatric: Denies Anxiety. Denies Depressed mood. Denies Substance abuse.
Physical

General: 7yo male appears stated age, slightly anxious about exam and shy during questions but able to answer questions and allow physical exam.

Vitals:
Temp 99.1 **HR** 71 **Oxygen sat** % 99, **Ht**: 45in **Wt** 70lb **BP** 115/83. **Pain scale** 0

Examination:
General Appearance: 7yo male appears stated age, slightly anxious about exam and shy during questions but able to answer questions and allow physical exam
Skin: no suspicious lesions, warm and dry , moist, no rash.
HEENT normocephalic, atraumatic, no scalp lesions.
Eyes: sclera non-icteric, upper eyelids normal, lower eyelids normal.
Ear: normal tympanic membranes, no discharge.
Throat: mild erythema. Clear, no exudates, uvula midline .
Cardiovascular: regular rate and rhythm, S1, S2 normal .
Respiratory: clear to auscultation bilaterally, good air movement, no wheezes, rales, rhonchi.
Gastrointestinal: soft, non-tender/non-distended, no guarding or rigidity, no masses palpable. Negative Rovsing, negative psoas, negative obturator. No tenderness at McBurney point.
Genitourinary: exam not done
Musculoskeletal no pain, swelling, tenderness.
Neurologic Exam: nonfocal, alert and oriented .
Extremities: , no clubbing, cyanosis, or edema; good tone and skin color.
Psychiatry cooperative with exam, good eye contact, speech clear.

Assessment
7yo M with subjective fever (102) and chief complaint of not feeling well x 12 hours. Pt denies sick contact, congestion, sore throat, ear pain, stomach pain.
Differential diagnoses

1. Upper Respiratory Infection (URI)
    a. Viral
    b. Bacterial

Tests:

- Covid-19 antigen and PCR
    - Antigen results: Negative
- Rapid Fluwash
    - Results: Positive
- Rapid Strep culture
    - Results: Negative

Plan

1. Medication prescribed:
   - Oseltamivir (Tamiflu) **Oral**: 60 mg twice daily x 5 days
     - Dosed by kg

This was chosen over oral one time dose (xofluza) due to insurance coverage.

2. Education
   a. Fever control: continue with motrin
   b. Precautions for return/ER: if fever/chills worsen, lethargy progresses or SOB occurs go to pediatric Emergency department